

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023369

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 751

FILED JUN 24 1963

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

|  |                           |   |                                    |
|--|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jackson                                |                                    |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph  |                           | Length of stay in 1b<br>23 yrs. 8mo. 10 days  |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION State Hospital #2   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                    |
| 3. NAME OF DECEASED<br>(Type or print) First FENI Middle SPECK Last  |                           | 4. DATE OF DEATH<br>Month June Day 14, Year 1963  |                                    |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/27/1902      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home   | 9. AGE (last birthday)<br>60       |
| 11a. FATHER'S NAME<br>William Lewis Arnold   |                           | 11b. MOTHER'S MAIDEN NAME<br>Ellen Coward   | 12. CITIZEN OF WHAT COUNTRY<br>USA |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>no  |                           | 17. INFORMANT<br>State Hospital Records, St. Joseph, Mo   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute CORONARY occlusion<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |                           |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Psychosis due to Meningoencephalitic Les  |                           |   |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                    |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                           |   |                                    |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year   |                           | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                           | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE  |                                    |
| 21. I attended the deceased from Oct 4 1939 to June 14 1962 and last saw her alive on June 14, 1962<br>Death occurred at p m on the date stated above, and to the best of my knowledge, from the causes stated.  |                           |   |                                    |
| 22a. SIGNATURE<br>(Degree or title)<br>Charles M. Clark MD   |                           | 22b. ADDRESS<br>State Hosp #2 St Joseph Mo  |                                    |
| 22c. DATE SIGNED<br>6-24-63  |                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>removal  |                                    |
| 23b. DATE<br>6/18/1963   |                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Kirksville Mo.  |                                    |
| 24. FUNERAL DIRECTOR<br>Heston - Bowman, St. Joseph, MO.   |                           | 25. DATE RECD. BY LOCAL REG.<br>June 20, 1963   |                                    |
| 26. REGISTRAR'S SIGNATURE<br>Mrs. Clark Handell  |                           |   |                                    |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

C.M. Clark, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535-

P. O. Address St Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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Permit issued 6-18-63